Wisconsin Department of Regulation & Licensing

Mail To: **P.O. Box 8935**
Madison, WI 53708-8935
1400 E. Washington Avenue
Madison, WI 53703
FAX #: (608) 261-7083
Phone #: **(608) 266-2112**
E-Mail: web@drl.state.wi.us
Website: http://drl.wi.gov

DENTISTRY EXAMINING BOARD

CONSCIOUS SEDATION PROVIDER SCHOOL VERIFICATION FORM

NOTE: THIS FORM MUST BE COMPLETED BY YOUR SCHOOL OR COURSE PROVIDER AND RETURNED TO DEPARTMENT OF REGULATION & LICENSING, HEALTH PROFESSIONS, PO BOX 8935, MADISON, WI 53708-8935

NOTE TO TRAINING COURSE PROVIDERS:

This form is for course providers to verify that courses already provided to individuals meet the requirements listed below for each category. If providers have not been approved, they may apply for course approval by submitting a syllabus that specifies the content, hours and clinical cases contained in the course to the department for review by the board.

APPLICANT – PLEASE COMPLETE THIS SECTION PLEASE TYPE OR PRINT IN INK

Last Name	First Name	MI	Former / Maiden Name(s)

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth
_____ _____ _____
month day year

Daytime Telephone Number
( ) _____ - _____

Social Security Number (Optional - for use by school to locate your records.) _____

CERTIFYING SCHOOL OR PROVIDER - PLEASE COMPLETE THE FOLLOWING SECTIONS WHICH APPLY

AFFIDAVIT FOR CLASS III

I attest to the fact that _____ completed
(Name of Applicant)

Check one box below:

- ☐ board approved postdoctoral training in the administration of deep sedation and general anesthesia **OR**
- ☐ successful completion of a postdoctoral training program in anesthesiology that is approved by the Accreditation Council for Graduate Medical Education **OR**
- ☐ successful completion of a minimum of one year advanced clinical training in anesthesiology provided it meets the objectives set forth in part 2 of the American Dental Association's "Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry."

_____
(Name of School/Provider)

_____
(Street, City, State, Zip)

_____
(Coursework Completion Date)

This school/provider was board approved on _____
(date)

_____ ( )_____
Signature of Dean or Department Head/Provider Phone Number

_____
Date

SCHOOL SEAL (if applies)

#2758 (9/06)
Ch. 460, Stats.

-OVER-

Wisconsin Department of Regulation & Licensing

AFFIDAVIT FOR CLASS II

I attest to the fact that _____ has
(Name of Applicant)

Check one box below:

☐ successfully completed at least 60 hours of didactic instruction which address the physical evaluation of patients, IV sedation and emergency management and 20 clinical cases managing parenteral routes of administration **OR**

☐ graduate level training approved by the board which includes the minimum requirements as set forth above.

_____
(Name of School/Provider)

_____
(Street, City, State, Zip)

_____
(Completion Date)

This institution/provider was board approved on _____.
(Date)

_____ ( )_____
Signature of Dean or Department Head/Provider Phone Number

_____
Date **SCHOOL SEAL (if applies)**

AFFIDAVIT FOR CLASS I

I attest to the fact that _____
(Name of Applicant)

Check one box below:

☐ has successfully completed at least 18 hours in didactic instruction which addresses physical evaluation of patients, conscious sedation-enteral, emergency management, and conforms to the principles in part one or part 3 of the American Dental Association's "Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry" and 20 clinical cases using an **enteral** route of administration to achieve conscious sedation, which may include group observation **OR**

☐ graduate level training approved by the board that, at a minimum, includes the requirements as set forth above.

_____
(Name of School/Provider)

_____
(Street, City, State, Zip)

_____
(Hours Completion Date)

This institution/provider was board approved on _____
(date)

_____ ( )_____
Signature of Dean or Department Head/Provider Phone Number

_____
Date **SCHOOL SEAL (if applies)**